

12636

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural White Hall				c. LENGTH OF STAY IN lb 75 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Creamery				e. STREET ADDRESS Harford Creamery			
3. NAME OF DECEASED (Type or print) Andrew Roy Anderson				4. DATE OF DEATH Month Nov. Day 18 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1884	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Owner	
10b. KIND OF BUSINESS OR INDUSTRY Gen. Farming			11. BIRTHPLACE (State or foreign country) Harford Creamery, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Lemon Anderson				14. MOTHER'S MAIDEN NAME Leuella Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-36-4490			
17. INFORMANT A. Irwin Anderson				Address White Hall, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (b), (c) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 day
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug 17 , 19 59 to Nov 17 , 19 59 that I last saw the deceased alive on Nov 17 , 19 59 , and that death occurred at 2 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Milner Bortner M.D.				ADDRESS (Street, city or town, state) White Hall Md			
DATE SIGNED 11/18/1959							
PHYSICIAN'S NAME (Type) Milner Bortner				White Hall, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11/20/1959			
22c. NAME OF CEMETERY OR CREMATORY Bethel				22d. LOCATION (City, town, or county) (State) Madonna Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Gutz				24a. REC'D BY REGISTRAR NOV 23 '59			
ADDRESS Jarrettsville, Md.				24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

1940-1941

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12593

12605

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belair</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u> 03X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Conv. Home</u>		d. STREET ADDRESS <u>Rt. 1 Box 313 Chapman Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>C.</u> Last <u>Anderson</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 13, 1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Schafer</u>		14. MOTHER'S MAIDEN NAME <u>Priscilla Clarke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Claude N. Anderson</u>		Address <u>Rt. 1 Box 313 Chapman Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage (#3)</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Dis.</u> DUE TO (c) <u>9 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertrophic Polyarthritides</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1/31</u> 19 <u>50</u> , to <u>11/25</u> 19 <u>59</u> , that I last saw the deceased alive on <u>11/24</u> 19 <u>59</u> , and that death occurred at <u>12:10</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clifford F. Hudson</u> M.D.		ADDRESS (Street, city or town, state) <u>FORK, MD.</u>	
PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>		DATE SIGNED _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 29, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lessahn Funeral Home</u> ADDRESS <u>7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>William S. Hunt</u>

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
AGE		SEX	
RACE		RELIGION	
MARRIAGE		EDUCATION	
OCCUPATION		RESIDENCE	
PREVIOUS ILLNESS		HISTORY	
SYMPTOMS		TREATMENT	
DIAGNOSIS		PROGNOSIS	
MANNER OF DEATH		CERTIFICATE	
SIGNATURE		DATE	
WITNESSES		DOCTOR	
FAMILY		CLERGY	
BURIAL		CREMATION	
CITY		COUNTY	
STATE		FEDERAL	
ZIP		COUNTRY	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12606

CERTIFICATE OF DEATH

12594

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE md. b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harre-de-Grace		c. LENGTH OF STAY IN lb 3 days.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alice S. Bull		4. DATE OF DEATH 11 7 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1875
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR: Months 11 Days 7 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY Housekeeper	
11. BIRTHPLACE (State or foreign country) Delta, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joshua Scotten		14. MOTHER'S MAIDEN NAME Mary J. McGibney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A.S.C.V.D. DUE TO (c) Senility		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonitis, bilateral		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 4th 1959 to Nov. 7th 1959 that I last saw the deceased alive on Nov. 7th 1959 and that death occurred at 3:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 211 N. Union Ave. DATE SIGNED 11/7/59 at 11 P.M.	
ACTUAL SIGNATURE Edward C. Loo M.D.		PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Nov. 10, 1959	
22c. NAME OF CEMETERY OR CREMATORY Rock Spring Episcopal Church Cem.		22d. LOCATION (City, town, or county) (State) Forest Hill, Harf. Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster ADDRESS W. Broadway & Williams St. BEL Air, Maryland		24a. REC'D BY REGISTRAR DATE NOV 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kump			

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12637

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b 3 Months 8 days 31 Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital, Aberdeen Proving Ground, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GUY Middle DEWAN Last CHANDLER		4. DATE OF DEATH Month November Day 11 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 4, 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	9. AGE (In years last birthday) yrs. 3 Months 8 Days 8 Hours Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clifton Howard Chandler		14. MOTHER'S MAIDEN NAME Emma Elizabeth Oliver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) N/A (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Father		Address 3 Aberdeen Ave, Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningitis (Hemophilus influenza) 340.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Increased intracranial pressure and possible adrenal gland exhaustion.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov 9 19 59 , to Nov 11 19 59 , that I last saw the deceased alive on 10 Nov 19 59 , and that death occurred at 9: 20 A. from the causes and on the date stated above.			
ACTUAL SIGNATURE Mark Eisenstein		ADDRESS (Street, city or town, state) US Army Hospital, Aberdeen Proving Ground, Maryland.	
DATE SIGNED Nov 16 '59		SIGNATURE Arthur S. Kraus	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/14/59	
22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		22d. LOCATION (City, town, or county) (State) Bel Air Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Farry		ADDRESS Aberdeen Maryland	
24a. REC'D BY REGISTRAR NOV 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MASSACHUSETTS
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS

1911

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1911

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12607

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u> 24	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>804 Park blv</u>	
3. NAME OF DECEASED (Type or print) First <u>GRACE</u> Middle <u>B.</u> Last <u>CHRISTIE</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27, 1904</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Fawn Grove, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Buchanan</u>		14. MOTHER'S MAIDEN NAME <u>Lottie Bond</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-16-8757</u>	
17. INFORMANT <u>Miss. Gloria Christie</u>		Address <u>894 Park blv Harre de Grace, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO 593X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u>Nephritis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/2</u> , 19 <u>59</u> , to <u>11/7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/7</u> , 19 <u>59</u> , and that death occurred at <u>9:10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury</u> M.D.		ADDRESS (Street, city or town, state) <u>349 Revolution St. Harre de Grace, Md.</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		DATE SIGNED <u>11/7/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 10, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. James Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Harre de Grace, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Otelia J. Bullock - Harre de Grace, Md</u>		24a. REC'D BY REGISTRAR <u>NOV 12 '59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>— S. Thoma</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1960

Form with multiple lines for text entry, including fields for name, date, and location. The form is oriented vertically on the page.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12638

CERTIFICATE OF DEATH

12597

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS None		
3. NAME OF DECEASED (Type or print) First Sallie Middle Louella Last Cochran			4. DATE OF DEATH Month November Day 14 Year 19 59		
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1875		9. AGE (In years to birthday) 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME William Caudle		14. MOTHER'S MAIDEN NAME Mary Walker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Oliver Cochran	
				Address Street, Maryland	

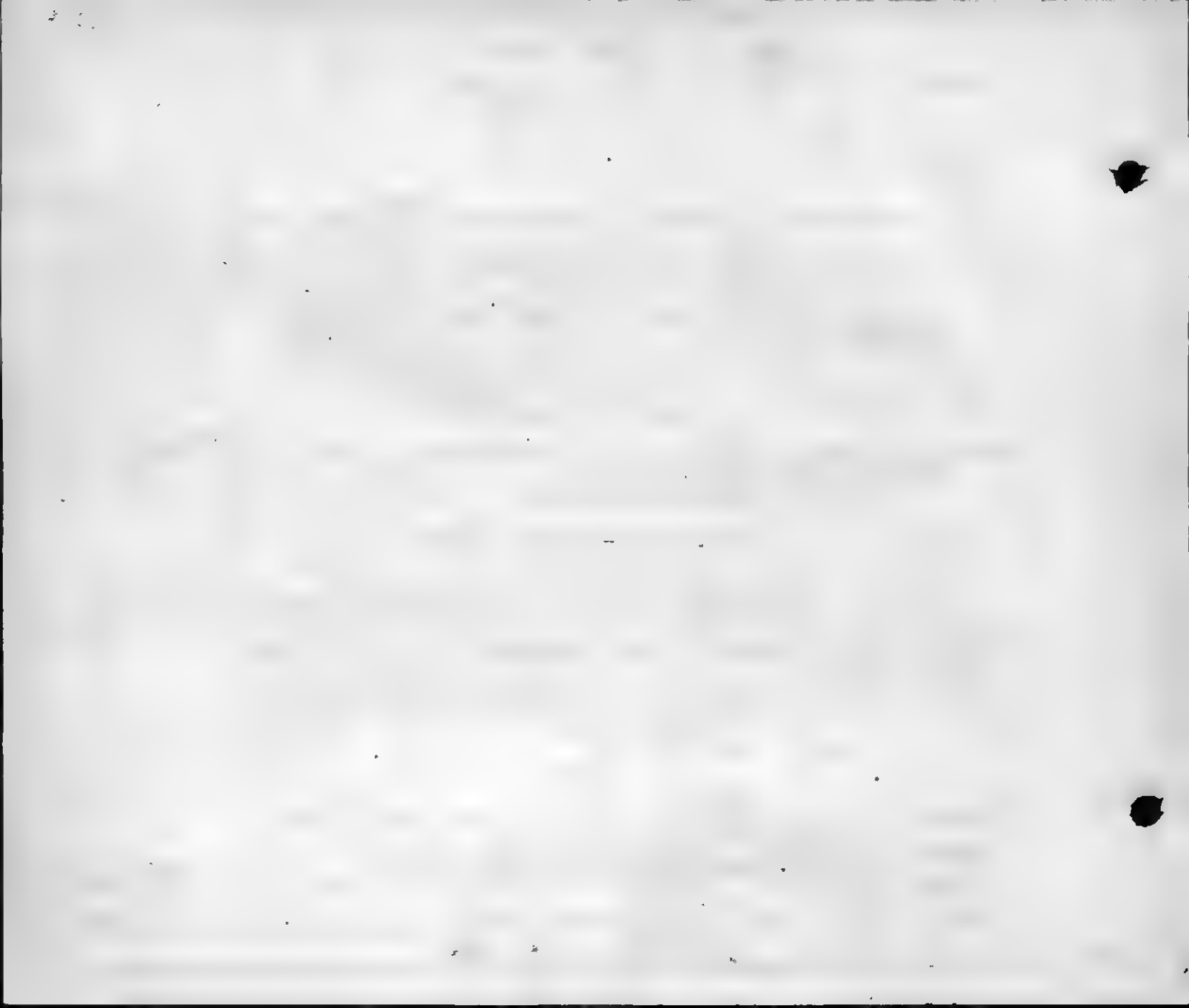
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHR. cardio-vascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 72 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1949 , 19____, to Nov. 14 , 19 59 , that I last saw the deceased alive on Nov. 14, 1959 , 12____, and that death occurred at 2 P M, from the causes and on the date stated above.	
ACTUAL SIGNATURE Willard P. Hudson	DATE SIGNED 11/14/59
PHYSICIAN'S NAME (Type) Willard P. Hudson	
ADDRESS (Street, city or town, state) Forest Hill, Maryland	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 17, 1959	22c. NAME OF CEMETERY OR CREMATORY Mountain View	22d. LOCATION (City, town, or county) (State) Sparta, North Carolina
23. FUNERAL DIRECTOR'S SIGNATURE H. R. Bailey		24. REGISTRAR'S SIGNATURE Carlton L. Hines	
ADDRESS Darlington, Md.		DATE Nov 18 59	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12598

Reg. Dist. No.

12608

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harreels Grace</u>		c. LENGTH OF STAY IN 1b <u>1 month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>230 Balto. Pike</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>C</u> Last <u>Cohen</u>				4. DATE OF DEATH Month <u>November</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 4 / 1875</u>		9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>		11. BIRTHPLACE (State or foreign country) <u>MS</u>		12. CITIZEN OF WHAT COUNTRY? <u>MS</u>	
13. FATHER'S NAME <u>Alex CORN</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Prigg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Thomas Williams</u> Address <u>Bel Air MD Box 284</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture R femur</u> <u>903.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Fell on floor of home</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>10-6</u> p.m. <u>1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Bel Air Harford MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, MD</u>		DATE SIGNED <u>11-9-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 12 / 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Clark's Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air Rural MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. Foster</u>				ADDRESS <u>Bel Air MD</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 13 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. J. H. H. H.</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 1 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12599

Reg. Dist. No.

12639

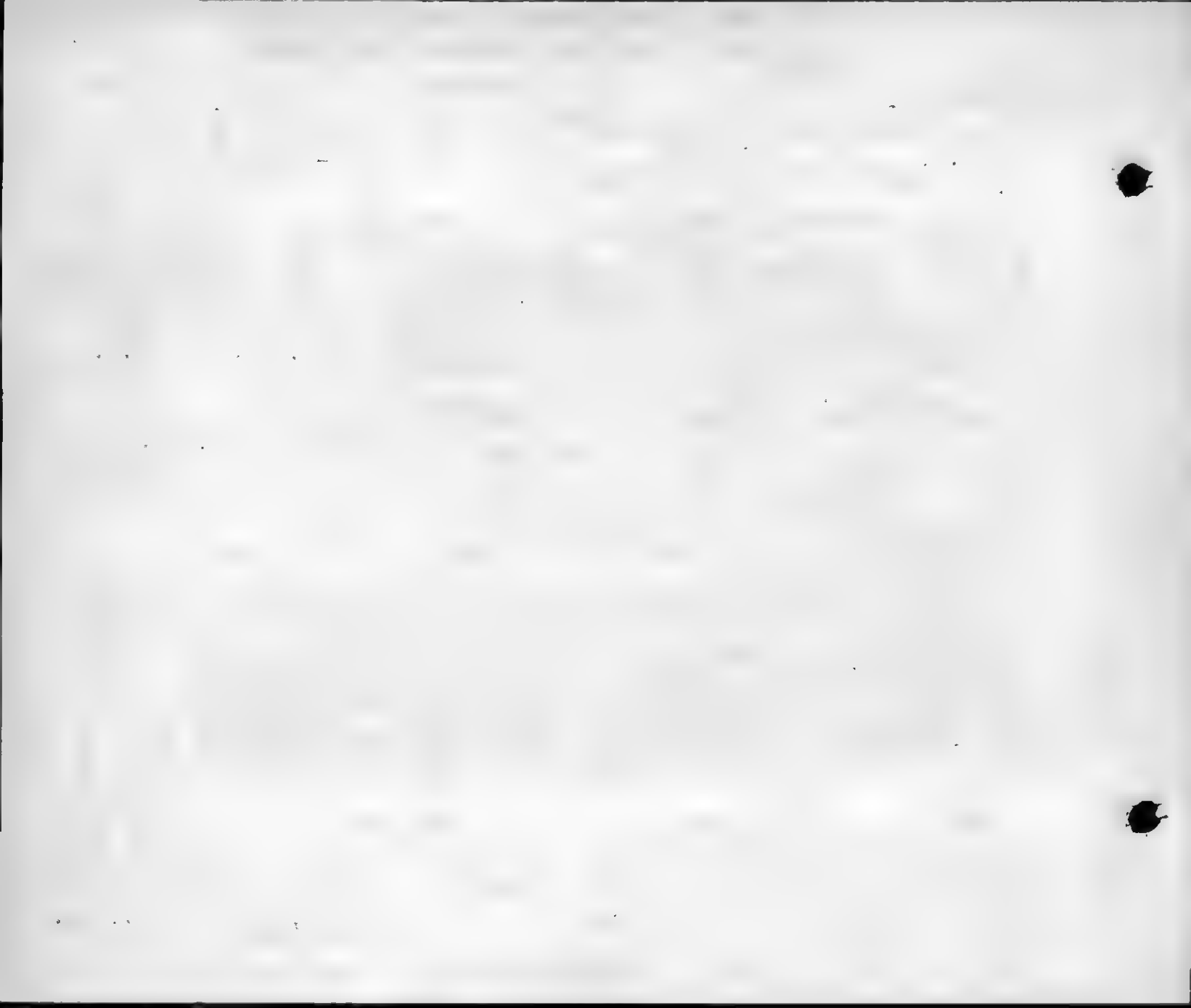
1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If Institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-Street</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u> * Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Davis Farm</u>		e. STREET ADDRESS <u>Street</u>	
3. NAME OF DECEASED (Type or print) <u>CARROLL F. Cullum</u>		4. DATE OF DEATH <u>November 16 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20, 1945</u>
9. AGE (In years last birthday) <u>14</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Fountain Green, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alfred W. Cullum</u>		14. MOTHER'S MAIDEN NAME <u>Grace K. Temple</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Alfred W. Cullum, Street, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>G S W Cerebrum</u> <u>119.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>119.8</u> (c) <u>119.8</u> DUE TO cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hunting Accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>2 11-16 59</u> Hour <u>am</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <u>Davis Farm</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) <u>Harford</u> (County) <u>Md.</u> (State)	
21. Certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Pc/Art</u> DATE SIGNED <u>MD 11-16-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-19-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ascension</u>	22d. LOCATION (City, town, or county) <u>Street, Harford Co., Md.</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins</u>		ADDRESS <u>Delta, Penna.</u>	
24a. REC'D BY REGISTRAR <u>NOV 18 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

12

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial/cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

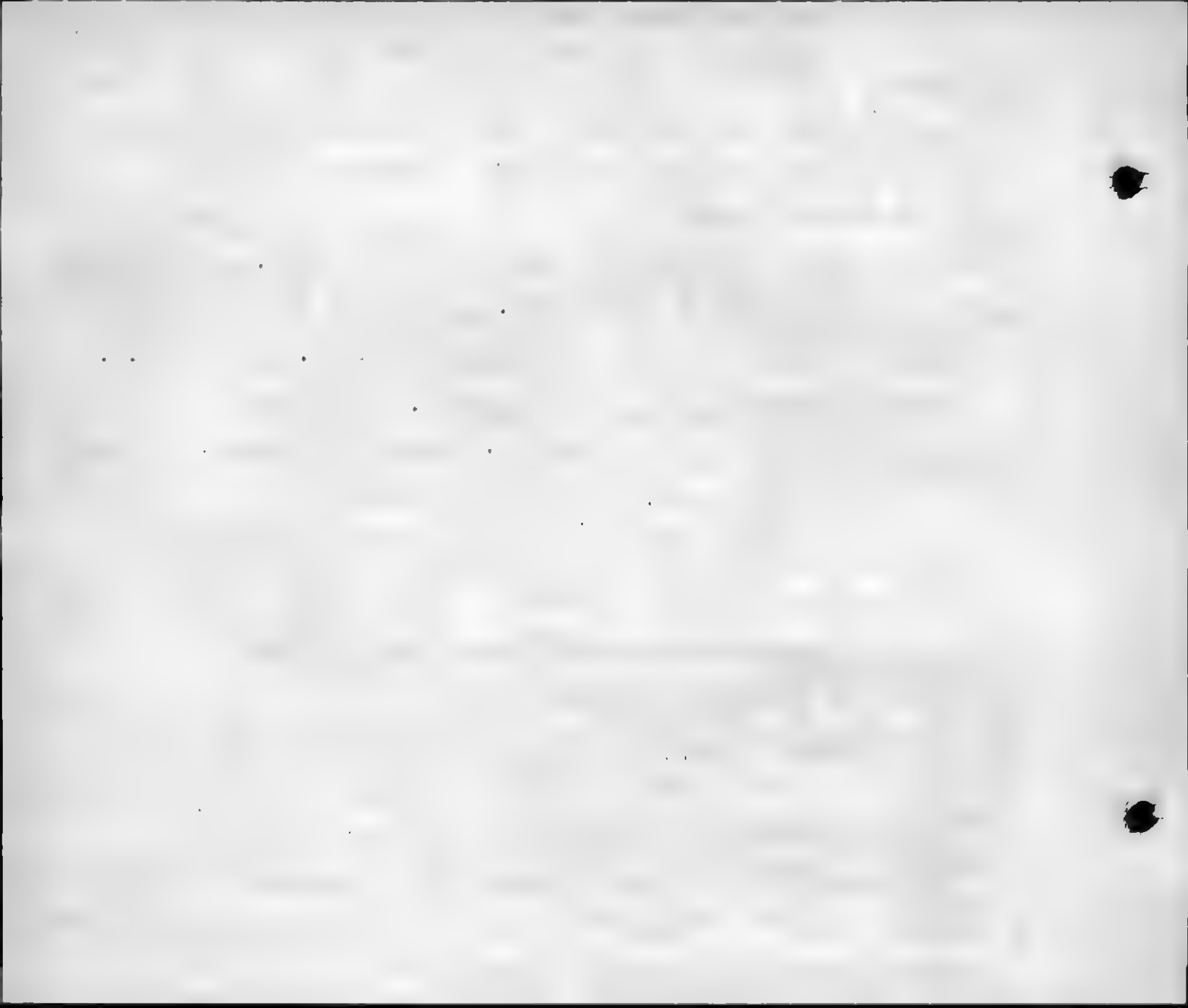
12600

12640

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Bel Air</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Convalescing Home</u>		e. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Bertie</u> Middle <u>Elizabeth</u> Last <u>Cursey</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 27 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Kingsville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Everhard Wirsing</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Rogers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Earl W. Cursey</u>		Address <u>Monkton, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>199.1</u> DUE TO <u>Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>(b) Carcinomatous dissemination of follicles</u> DUE TO <u>upper third R. thigh</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Hyperlipidemia (cardiomas. Dis. Hypertrophic cardiomyopathy)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 mos.</u> <u>40 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/25</u> , 19 <u>59</u> to <u>11/3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12</u> , and that death occurred <u>1:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Clifford F. Hudson, Fort, Md.</u> DATE SIGNED <u>CLIFFORD F. HUDSON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/6/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Jarrettsville</u>		22d. LOCATION (City, town, or county) (State) <u>Jarrettsville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Rust</u>		ADDRESS <u>Jarrettsville Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12609

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>	
c. LENGTH OF STAY IN 1b <u>46 yrs.</u>		d. STREET ADDRESS <u>Harren + Chis Sts. Ept.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harren + Chis Sts. Ept.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>R.</u> Last <u>Dyson</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 12, 1889</u>
9. AGE (In years last birthday) <u>70 yrs</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>9</u> Days <u>14</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Claggett Dyson</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>217-03-1025</u>	
17. INFORMANT <u>Mrs. Estella T. Dyson Harre de Grace Md.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinoma of Pancreas.</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>3 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 10, 1959</u> to <u>November 26, 1959</u> , that I last saw the deceased alive on <u>Nov 26</u> , 19 <u>59</u> , and that death occurred at <u>1</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank Wolbert MD</u> M.D.		ADDRESS (Street, city or town, state) <u>Harre de Grace Md</u>	
PHYSICIAN'S NAME (Type) <u>FRANK WOLBERT MD</u>		DATE SIGNED <u>11/27/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 30, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Abertown Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Otelia J. Bullock</u>		ADDRESS <u>Harre de Grace, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12602

12641

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Cross Roads				c. LENGTH OF STAY IN 1b 40 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELVA, Idelle First Middle Last				4. DATE OF DEATH Nov 27 1959 Month Day Year			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1894		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Jarrettsville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Dixon				14. MOTHER'S MAIDEN NAME Susan Emma Chenworth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-01-0917		17. INFORMANT Address Mrs. Robert Parks Fallston, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 179.2 CARCINOMA TOXIS DUE TO (b) Metastatic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH 16 Months 2 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour s. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 25 1959 to 27 Nov 1959 , that I last saw the deceased alive on 25 Nov 1959 , and that death occurred at 11 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Thos. A. E. Moseley Jr. M.D.				ADDRESS (Street, city or town, state) Jarrettsville, Md. DATE SIGNED 27 Nov 1959			
PHYSICIAN'S NAME (Type) Thomas A. E. Moseley Jr. Jarrettsville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/30/1959		22c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens		22d. LOCATION (City, town, or county) (State) Bel Air, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Martin G. Kurtz, Jarrettsville, Md.				24a. REC'D BY REGISTRAR Nov 30 1959		24b. REGISTRAR'S SIGNATURE Wm. E. Moseley	



12610

MEDICAL CERTIFICATION

V5 A15 (4)
15M 9/55

215, 1816





12612

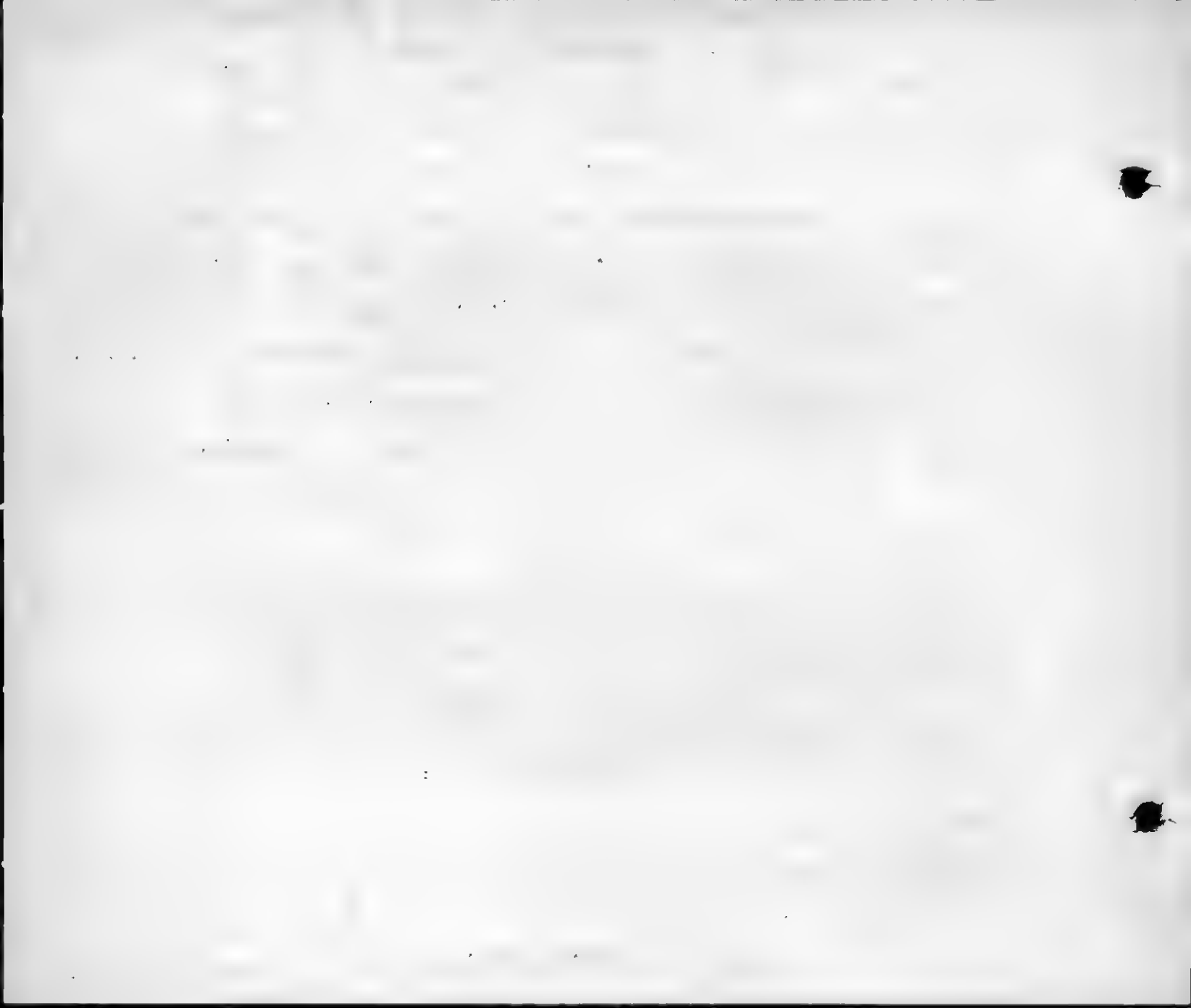
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm ssion) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air				c. LENGTH OF STAY IN lb 30 yrs.,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Roland Middle S. Last Fisher				4. DATE OF DEATH Month Nov. Day 4 Year 19 59			
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27, 1902		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dealer				10b. KIND OF BUSINESS OR INDUSTRY Junk		11. BIRTHPLACE (State or foreign country) Churchville, Maryland.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.,				13. FATHER'S NAME Charles Fisher			
14. MOTHER'S MAIDEN NAME Henrietta Johnson				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO none				17. INFORMANT Katherine Fisher Address Bel Air, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Of Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None							INTERVAL BETWEEN ONSET AND DEATH ??
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July , 19 58 , to Nov 3 , 19 59 , that I last saw the deceased alive on Nov 3 , 19 59 , and that death occurred at 11:45PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill Md DATE SIGNED 11/5/59							
ACTUAL SIGNATURE Willard P. Hudson M.D.				PHYSICIAN'S NAME (Type) Willard P. Hudson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Nov. 9, 1959		22c. NAME OF CEMETERY OR CREMATORY Mount Zion	
22d. LOCATION (City, town, or county) Joppa				22e. (State) Harford		22f. (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McCoun				ADDRESS Abingdon, Maryland.		24a. REC'D BY REGISTRAR DATE NOV 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas							

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12606

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY IN 1b —		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Magnolia</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Do A Harford Memorial Hospital</u>				d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Theodore</u> E. Middle <u>Gilbert</u> Last <u>Gilbert</u>				4. DATE OF DEATH Month <u>November</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 17, 1910</u>		9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trackman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Magnolia, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James B. Gilbert</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Robinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>212 12-6366</u>		17. INFORMANT <u>Rebecca Gilbert</u>		Address <u>Joppa, Maryland.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto pedestrian type</u>					
20c. TIME OF INJURY Month, Day, Year <u>Nov. 11-13 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>US Route 40</u>		20f. (City or town) (County) (State) <u>Joppa Harford Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Donald C Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u>		DATE SIGNED <u>11-13-59</u>	
EXAMINER'S NAME (Type) <u>Donald C Palmer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 16, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Magnolia Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Magnolia Harford Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard P. McCombs Jr</u>				ADDRESS <u>Abingdon, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 16 1959</u>	
				24b. REGISTRAR'S SIGNATURE <u>not signed</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12608

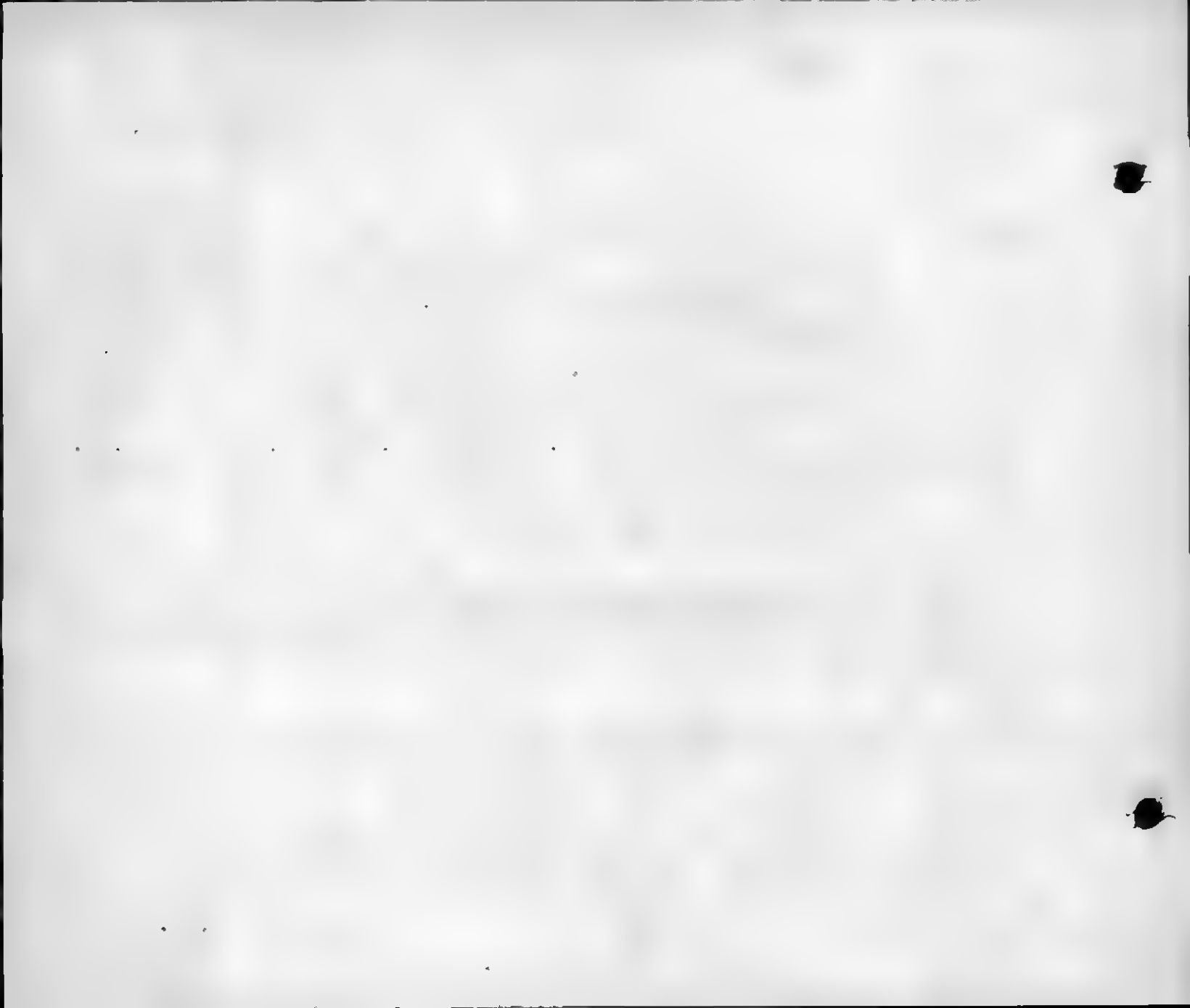
Reg. Dist. No.

<p>12615</p> <p>1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u> ✓</p>			
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampden Kres</u></p>			<p>c. LENGTH OF STAY IN 1b <u>1 Day</u></p>	<p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u></p>			
<p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u></p>				<p>e. STREET ADDRESS <u>Box 231 R D 1</u></p>		<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) <u>Christina May Higgins</u> First Middle Last</p>				<p>4. DATE OF DEATH <u>November 18</u> 19 <u>59</u> Month Day Year</p>			
<p>5. SEX <u>F</u></p>	<p>6. COLOR OR RACE <u>W</u></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>July 14, 1924</u></p>		<p>9. AGE (In years) <u>35</u> yrs.</p>	<p>IF UNDER 1 YEAR Months Days</p>	<p>IF UNDER 24 HRS. Hours Min.</p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>Ohio</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>	
<p>13. FATHER'S NAME <u>Jacob W. Zinger</u></p>				<p>14. MOTHER'S MAIDEN NAME <u>Fannie Shrock Shrock</u></p>			
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u></p>		<p>16. SOCIAL SECURITY NO. <u>221-16-9880</u></p>		<p>17. INFORMANT Address <u>Williams L. Higgins, North East, MD Rural</u></p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured R hip</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____</p>							
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____</p>							
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>							
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/></p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident auto auto type</u></p>			
<p>20c. TIME OF INJURY Month, Day, Year <u>11-17 1959</u></p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>US Route 40</u></p>		<p>20f. (City or town) (County) (State) <u>Hampden Kres Harford Md</u></p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.</p>							
<p>ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.</p>				<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>md</u></p>			
<p>EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u></p>				<p>DATE SIGNED <u>11-18</u></p>			
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>22b. DATE THEREOF <u>11-20-1959</u></p>		<p>22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u></p>		<p>22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u></p>	
<p>23. FUNERAL DIRECTOR'S SIGNATURE <u>Vela Patterson & Son</u></p>				<p>ADDRESS <u>Perryville, Md.</u></p>		<p>24a. REC'D BY REGISTRAR <u>NOV 20 1959</u></p>	
<p>24b. REGISTRAR'S SIGNATURE <u>[Signature]</u></p>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12649

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY 12616 Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Aldino Road		1d. STREET ADDRESS Aldino Road	
3. NAME OF DECEASED (Type or print) Richard M. Hopkins		4. DATE OF DEATH November 20 1959	
5. SEX MA	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 1, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. J. Hopkins		14. MOTHER'S MAIDEN NAME IDA FORSYTHE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT Wm. John Hopkins		Address HAYREDE GRACE MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2 SW neck 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 SW L occipital region			
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self twice with his shot gun	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 11-20 1959 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Aberdeen (County) Harford (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE: Gerald C Palmer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air MD DATE SIGNED 11-20-59	
EXAMINER'S NAME (Type): Gerald C Palmer M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-23-1959	
22c. NAME OF CEMETERY OR CREMATORY DARLINGTON CEM.		22d. LOCATION (City, town, or county) HARFORD CO (State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE R. MADISON MITCHELL		24a. REC'D BY REGISTRAR HAYREDE GRACE DATE NOV 25 '59	
ADDRESS MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



12617

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Brian</u> Middle <u>Douglas</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 22, 1959</u>
9. AGE (In years lost birthday) <u>2 days</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Howard Douglas Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Virginia REED</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mr. Howard D. Johnson</u>		Address <u>Box 124 C Joppa, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>760.0 SUBARACHNOID HEMORRHAGE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c). (b) <u>INTRA UTERINE DAMAGE - PREMATURE</u> DUE TO (c) <u>SEPARATION PLACENTA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4.5 HRS</u> <u>45 HRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>—</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 22</u> , 19 <u>59</u> , to <u>Nov 24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 24</u> , 19 <u>59</u> , and that death occurred at <u>8:10 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D. <u>307 Hickory</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Nov 24, '59</u>	
PHYSICIAN'S NAME (Type) <u>Philip W. Heuman, M.D. Bel Air, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 25, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Air, Harford Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Fater</u> ADDRESS <u>W. Broadway + Williams St. Bel Air, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 27 '59</u>	24b. REGISTRAR'S SIGNATURE <u>C. L. H. & H. H. H.</u>

TO HOSPITAL OF THE ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2 71204A/4



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12642

12611

12642

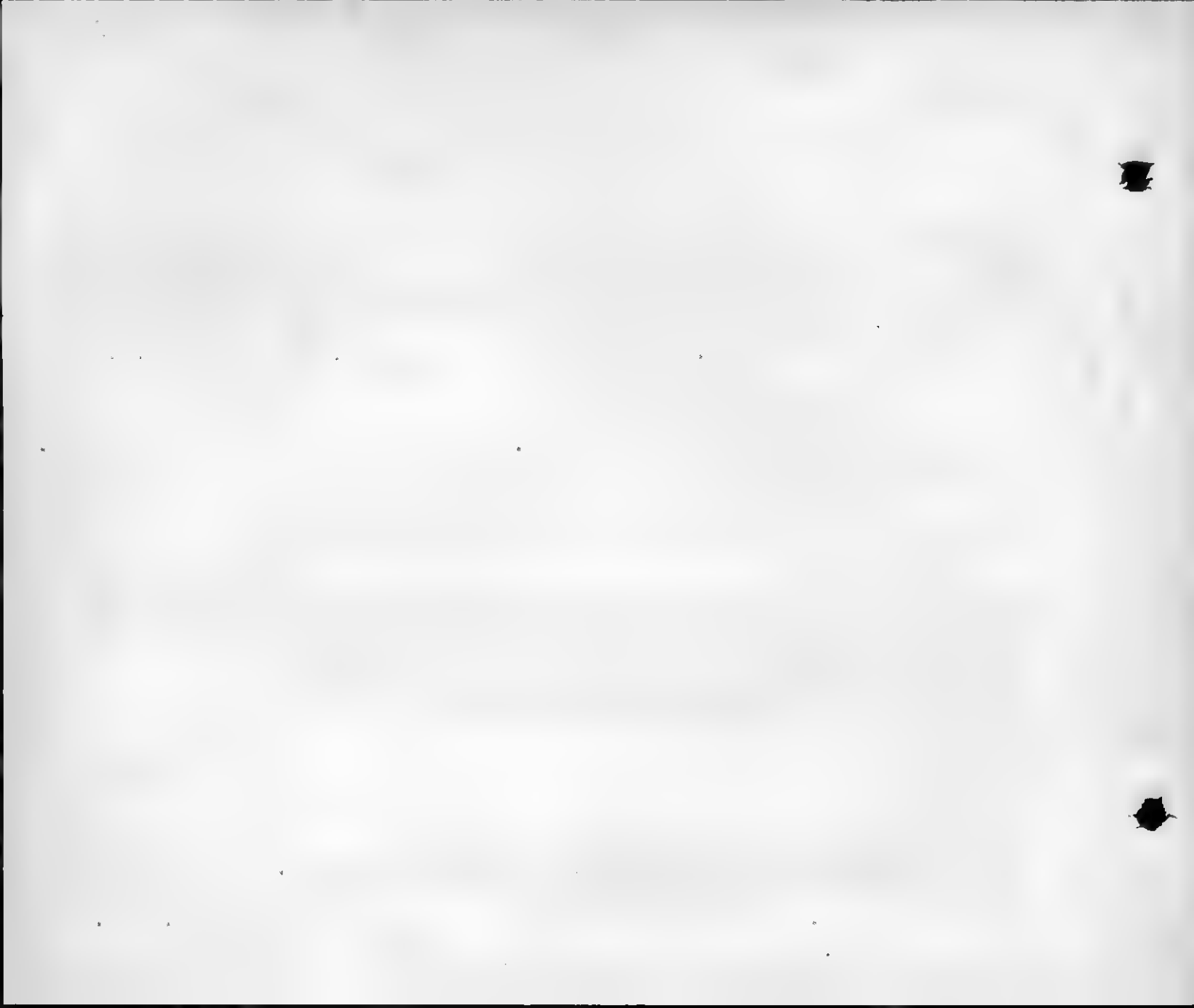
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ma. b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whiteford		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whiteford	
c. LENGTH OF STAY IN b 58 years		d. STREET ADDRESS Whiteford	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Warfield Benjamin Jones		4. DATE OF DEATH Month Day Year November 15, 19 59	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 18, 1903
9 AGE (In years last birthday) 56 yrs.		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Co. Highway Dept.	
11. BIRTHPLACE (State or foreign country) Whiteford, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Jones		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 008-07-8624	
17. INFORMANT Mrs. Margaret M. Jones, Whiteford, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive cardiovascular disease DUE TO (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 4 hr. 2-3 yr known 1 yr.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Therapies - spinal cord - surgically removed Sept. complete		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edwin W. Whiteford Jr. MD		ADDRESS (Street, city or town, state) Whiteford, Maryland	
PHYSICIAN'S NAME (Type) Edwin W. Whiteford, Jr.		DATE SIGNED 11/14/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 18, 1959	
22c. NAME OF CEMETERY OR CREMATORY Slate Ridge		22d. LOCATION (City, town, or county) (State) Delta, York Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harrison		ADDRESS Delta, Penna.	
24a. REC'D BY REGISTRAR NOV 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12612

Reg. Dist. No.

12643

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Toppa</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Toppa</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>68 Shirley Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Diana Lynn Knopp</u>		4. DATE OF DEATH <u>November 22 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1959</u>
9. AGE (In years last birthday) <u>4</u> yrs.		10. IF UNDER 1 YEAR <u>4</u> Months <u>4</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Harrods Creek, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel Augustus Knopp</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Ellen Hilditch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Miss Samuel A Knopp</u>		Address <u>Toppa, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>—</u> a. m. <u>—</u> p. m. <u>—</u> 19 <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Lerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11-22-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick Green Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Hunt</u>		24a. REC'D BY REGISTRAR <u>NOV 27 59</u> DATE	24b. REGISTRAR'S SIGNATURE <u>William S. Hunt</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



12618

CERTIFICATE OF DEATH

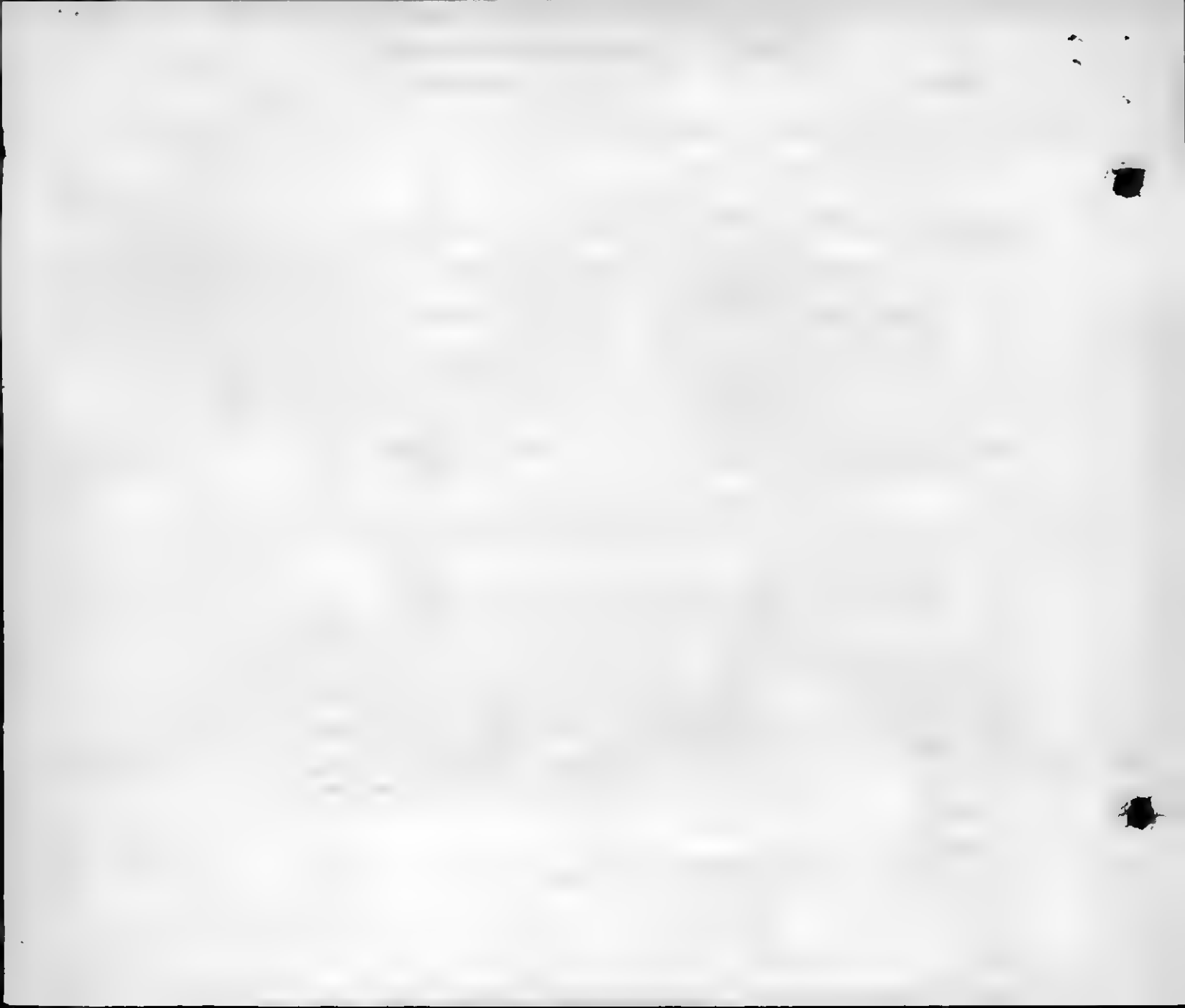
12613

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harpford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harpford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harpford</u>	
c. LENGTH OF STAY IN 1b <u>11 days</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Harpford Memorial Hospital</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1d STREET ADDRESS <u>Rt. # 2 Box 130</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>E.</u> Last <u>Maloy</u>		4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 27, 1915</u>
9. AGE (In years last birthday) <u>44</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Research Engineer APG</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Maloy Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Hazel Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>171-12-6690</u>	
17. INFORMANT <u>Norothy Maloy</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Pulmonary Embolism</u> DUE TO <u>Thrombo-phlebitis recurrent</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 yrs</u> DUE TO (c) <u>2 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral pneumonia, hemorrhages</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 1957</u> to <u>Nov 1959</u> , that I last saw the deceased alive on <u>Nov 24, 1959</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Ralph Horky</u> M.D.		ADDRESS (Street, city or town, state) <u>Churchville</u>	
PHYSICIAN'S NAME (Type) <u>J. Ralph Horky M.D.</u>		DATE SIGNED <u>Nov 25, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/27/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Memorial Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Bethel Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Garring</u>		ADDRESS <u>Aberdeen Maryland</u>	
24a. REC'D BY REGISTRAR <u>NOV 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 11 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12619

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harver de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Northeast Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Route 7</u>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Corklin</u> Last <u>MAUS</u>		4. DATE OF DEATH Month <u>November</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-31-1912</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Emery Platt Corklin</u>		14. MOTHER'S MAIDEN NAME <u>Helena Balentine</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>051-16-7261</u>	
17. INFORMANT Address <u>Arthur Maus, North East, Md.</u>		18. R F D, <u>1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism (Pul)</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Phlebotomy at internal</u> DUE TO (c) <u>iliac vein laceration at surgery</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 14</u> , 1959, to <u>Nov 19</u> , 1959, that I last saw the deceased alive on <u>11/19/59</u> , 1959, and that death occurred at <u>9:27</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm K Brendle</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Wm K. Brendle</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-23-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Patterson</u> ADDRESS <u>Perryville, Md</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 23 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



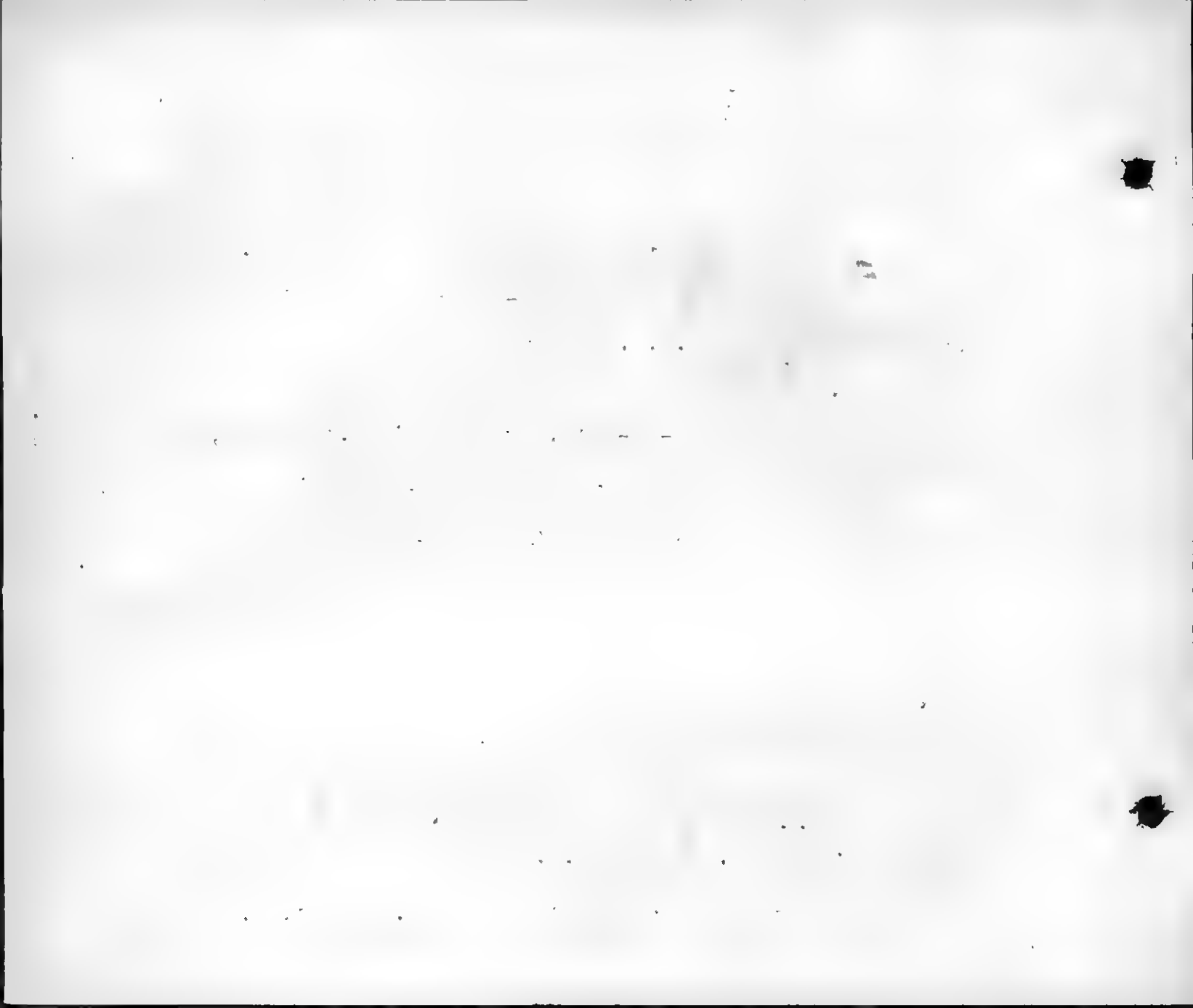
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12620
CERTIFICATE OF DEATH

12615

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN lb 19 Hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Liberty Grove -78			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial				d. STREET ADDRESS New Valley		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ralph Middle Ernest Last McCardell				4. DATE OF DEATH Month Nov. Day 26 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-19- 1911		9. AGE (In years last birthday) yrs 48	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator		10b. KIND OF BUSINESS OR INDUSTRY U.S.P.Grounds		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ernest B. McCardell				14. MOTHER'S MAIDEN NAME Lidie Morrison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-09-1712		INFORMANT Address Md. Mrs. Cornelia McCardell, Liberty Grove,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRAGE - 291X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROSIS - DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 19 hours - 44 W						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEBRUARY 19 - 1959 that I last saw the deceased alive on NOV - 76 , 19 59 , and that death occurred at 11:10 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Clarence L. Benson M.D.		ADDRESS (Street, city or town, state) 1221 1st St. Perryville, Md.		DATE SIGNED 11/27/59			
PHYSICIAN'S NAME (Type) Clarence L. Benson M.D.							
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-30-1959		22c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem.		22d. LOCATION (City, town, or county) (State) Colora, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Clarence L. Benson		ADDRESS Perryville, Md		24a. REC'D BY REGISTRAR DATE NOV 30 59		24b. REGISTRAR'S SIGNATURE Arthur S. Thane	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



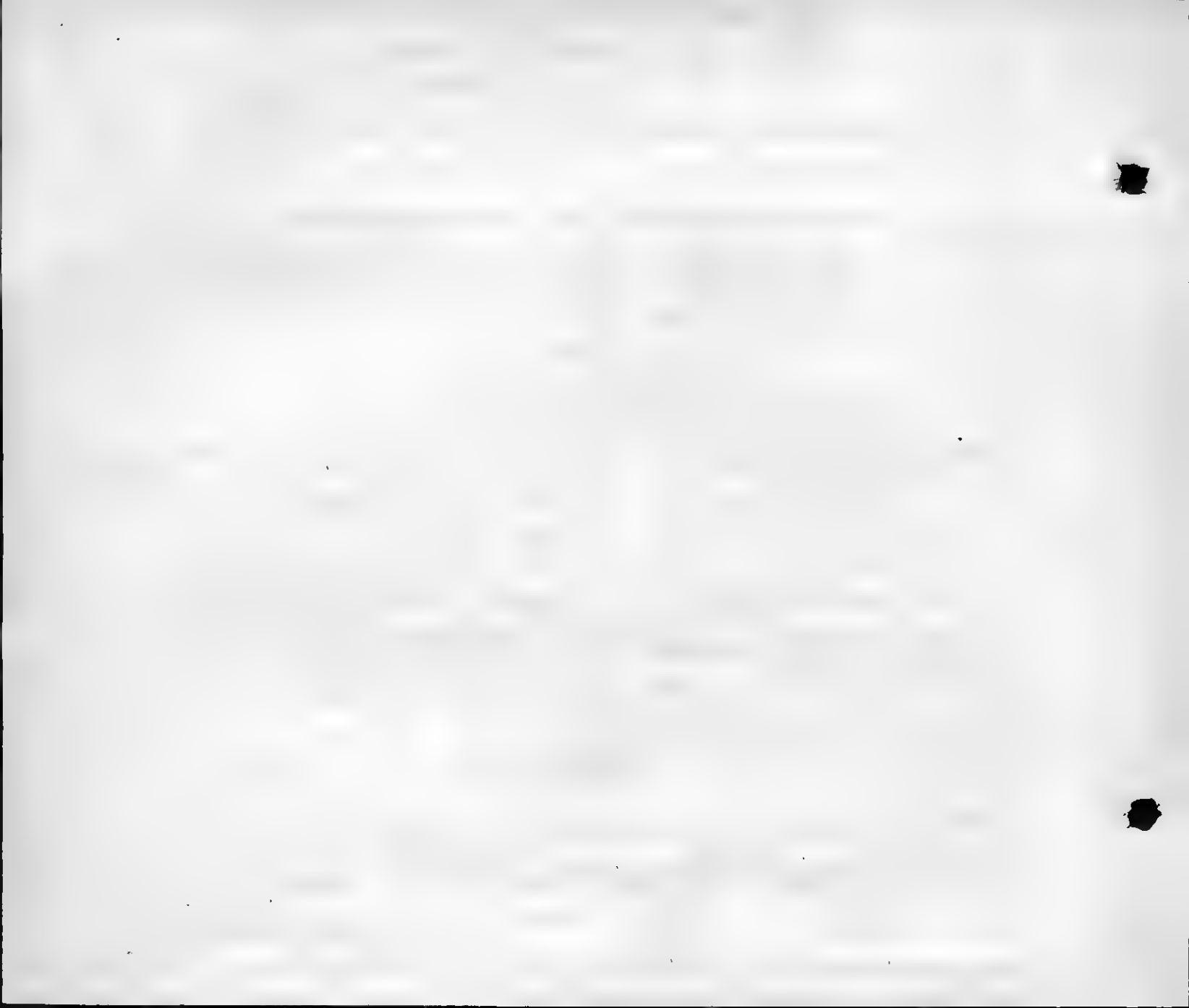
12621

CERTIFICATE OF DEATH

Reg. Dist. No.

12616

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 BEL AIR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>112 W. GORDON</u>		d. STREET ADDRESS <u>112 W. GORDON</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HERBERT JEFFERSON MILLER</u>		4. DATE OF DEATH Month Day Year <u>NOVEMBER 8 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WH</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 21, 1873</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GROCER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERIES</u>	
11. BIRTHPLACE (State or foreign country) <u>LOPPA, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>WILLIAM JOHNSTON MILLER</u>		14. MOTHER'S MAIDEN NAME <u>EMILY REBECCA SPICER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-32-3473</u>	
17. INFORMANT <u>MRS TAMSYE MILLER</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANOXIA-CONGESTIVE FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ANEMIA, APLASTIC</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 MIN</u> <u>OVER 2 YRS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY</u> 19 <u>57</u> , to <u>NOV 8</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 8</u> 19 <u>59</u> , and that death occurred at <u>2:35 PM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D.		ADDRESS (Street, city or town, state) <u>307 HICKORY BEL AIR MD</u>	
PHYSICIAN'S NAME (Type) <u>PHILIP W. HEUMAN, M.D.</u>		DATE SIGNED <u>Nov 8, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 11/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mount Christian</u>		22d. LOCATION (City, town, or county) (State) <u>Joppatowne Maryland MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph H. Foster, Bel Air Md</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 10 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial/transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12617

12622

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		STATE <u>Md</u>		COUNTY <u>HARTFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bel Air Md</u>		LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bel Air MD 3 Box 211</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>Md</u>					
3. NAME OF DECEASED (First) (Middle) (Last) <u>McHenry Mitchell</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 4 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Dec 4-1879</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hartford Co. Md</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Mitchell</u>		14. MOTHER'S MAIDEN NAME <u>Alice Duval</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If Yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-03-0131</u>		17. INFORMANT & ADDRESS <u>Charles R. Richardson, Bel Air MD 3 Box 211</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						<u>10 minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension C.V. Disease + Arterioscl.</u>						<u>5 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes Mellitus - controlled</u>						<u>5 years</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 4 1959</u> to <u>Nov 4 1959</u> that I last saw the deceased alive on <u>Nov 4 1959</u> and that death occurred at <u>11:15 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles R. Richardson, M.D.</u>				ADDRESS (Street, city, town, state) <u>Bel Air, Md</u>			
DATE SIGNED <u>11/4/59</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Nov 4/59</u>		NAME OF CEMETERY OR CREMATORY <u>St Mary's Episcopal</u>		LOCATION (City, town, or county) (State) <u>EMMORTON, HARTFORD, MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Charles S. Kane</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u>		ADDRESS <u>Bel Air, Md</u>	
DATE <u>NOV 6 '59</u>							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12618

Reg. Dist. No.

12623

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>POA Harford Memorial Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Billy</u> First <u>Joe</u> Middle <u>Nelson</u> Last				4. DATE OF DEATH <u>November 18</u> Month <u>18</u> Day <u>1959</u> Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 18, 1944</u>	
9. AGE (In years last birthday) <u>15</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>Frank Nelson</u>				14. MOTHER'S MAIDEN NAME <u>Arthur Lee Richardson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs., Arthur Lee Nelson</u> Address <u>Joppa Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto pedestrian type</u>					
20c. TIME OF INJURY Month, Day, Year <u>11-18-59</u> Hour <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>Joppa</u> (County) <u>Harford</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>				M.D. CHIEF MEDICAL EXAMINER <u>Bel Air</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>				ASSISTANT MEDICAL EXAMINER <u> </u>			
				DEPUTY MEDICAL EXAMINER <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 21, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Abingdon Harford Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. Miller Jr</u>				ADDRESS <u>Abingdon, Md.,</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 24 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 File 625-11-24-9

12619

12624

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hanford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hanford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wilson Street</u> (Visiting friends)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>—</u> Last <u>Nickas</u>		4. DATE OF DEATH Month <u>November</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6 - 1888</u>
9. AGE (In years last birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Self employed Restaurant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Nikakia</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-32-2884</u>	
17. INFORMANT <u>Mary C. Terenos - Bel Air Maryland</u>		Address <u>Bel Air Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> 420.1 DUE TO (b) <u>Acute Heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Hypertension, Coronary insufficiency</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>6 months</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>59</u> , to <u>Nov 13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 13 - 59</u> , 19 <u>59</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Andre Weiss</u>		ADDRESS (Street, city or town, state) <u>114 W. Bel Air Avenue</u> DATE SIGNED <u>11/16/59</u>	
PHYSICIAN'S NAME (Type) <u>ANDRE WEISS</u>		<u>Aberdeen, Md.</u>	
22a. BURIAL, CREMATON, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/17/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Aberdeen Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Derrig Aberdeen, Md.</u>		24. REC'D BY REGISTRAR <u>NOV 19 1959</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12625

CERTIFICATE OF DEATH

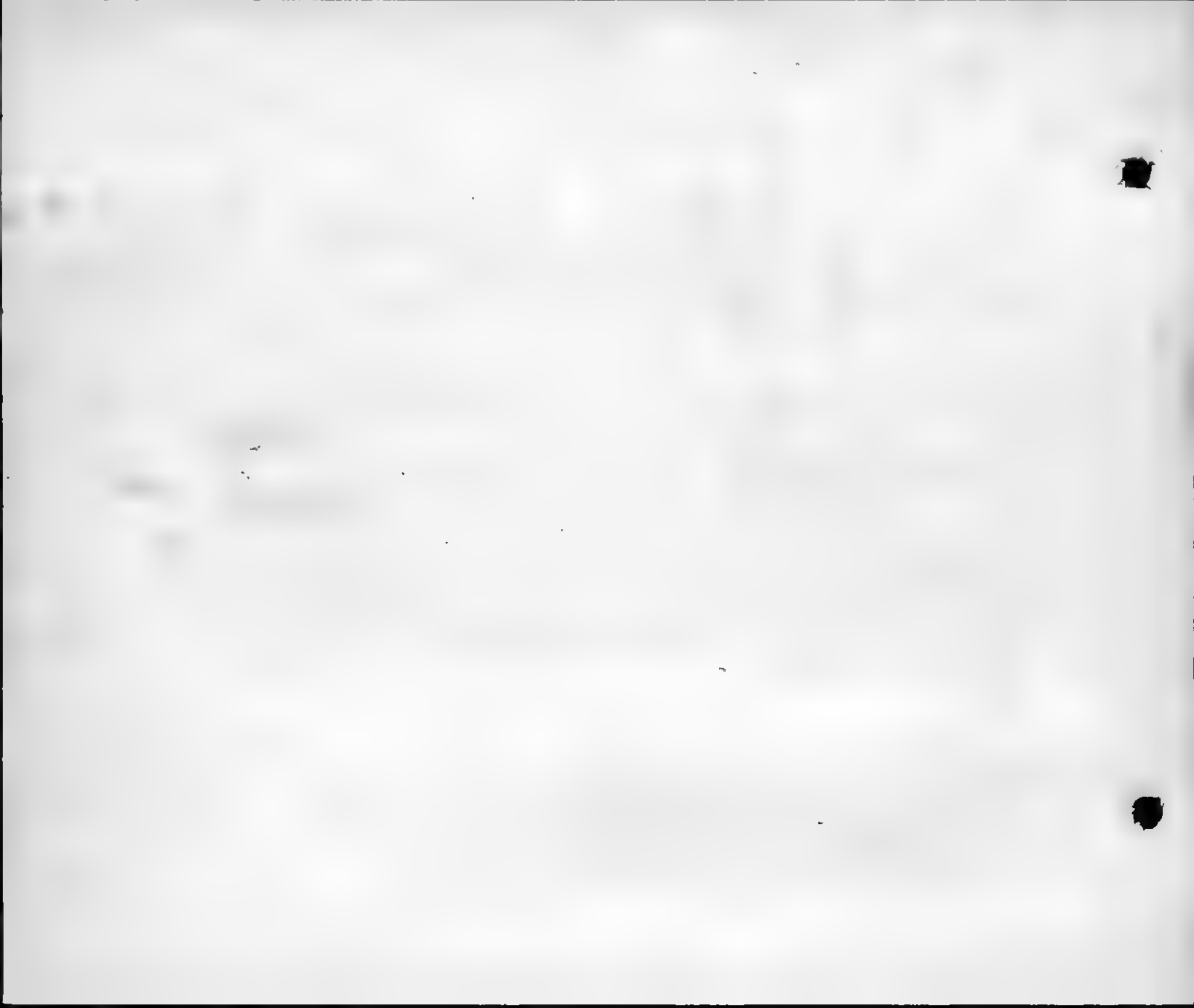
12620

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Haryford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Haryford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bed A n</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bed A n</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Baltimore Pike</u>		d. STREET ADDRESS <u>1234 Baltimore Pike</u>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>E.</u> Last <u>ROSS</u>		4. DATE OF DEATH Month <u>November</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27, 1894</u>
9. AGE (In years last birthday) <u>65 yrs</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>23</u> IF UNDER 24 HRS Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u>	
11. BIRTHPLACE (State or foreign country) <u>Keenemont, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry Ross</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Jasper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>212-38-2448</u>	
17. INFORMANT <u>Miss Corbelle Buff</u>		Address <u>234 Balt Pike</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma ascending colon</u> 1 <u>3.0</u> DUE TO <u>with wide metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>59</u> to <u>Nov 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 20</u> , 19 <u>59</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gerold C Palmer</u> M.D.		ADDRESS (Street, city or town, state) <u>Bed A n, Md</u> DATE SIGNED <u>11-20-59</u>	
PHYSICIAN'S NAME (Type) <u>Gerold C Palmer MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-24-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Eden Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bed A n, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Kline</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Kline</u> DATE <u>NOV 25 '59</u>	
ADDRESS <u>Arthur L. Kline</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: Affix this certificate to the death certificate and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12644

CERTIFICATE OF DEATH

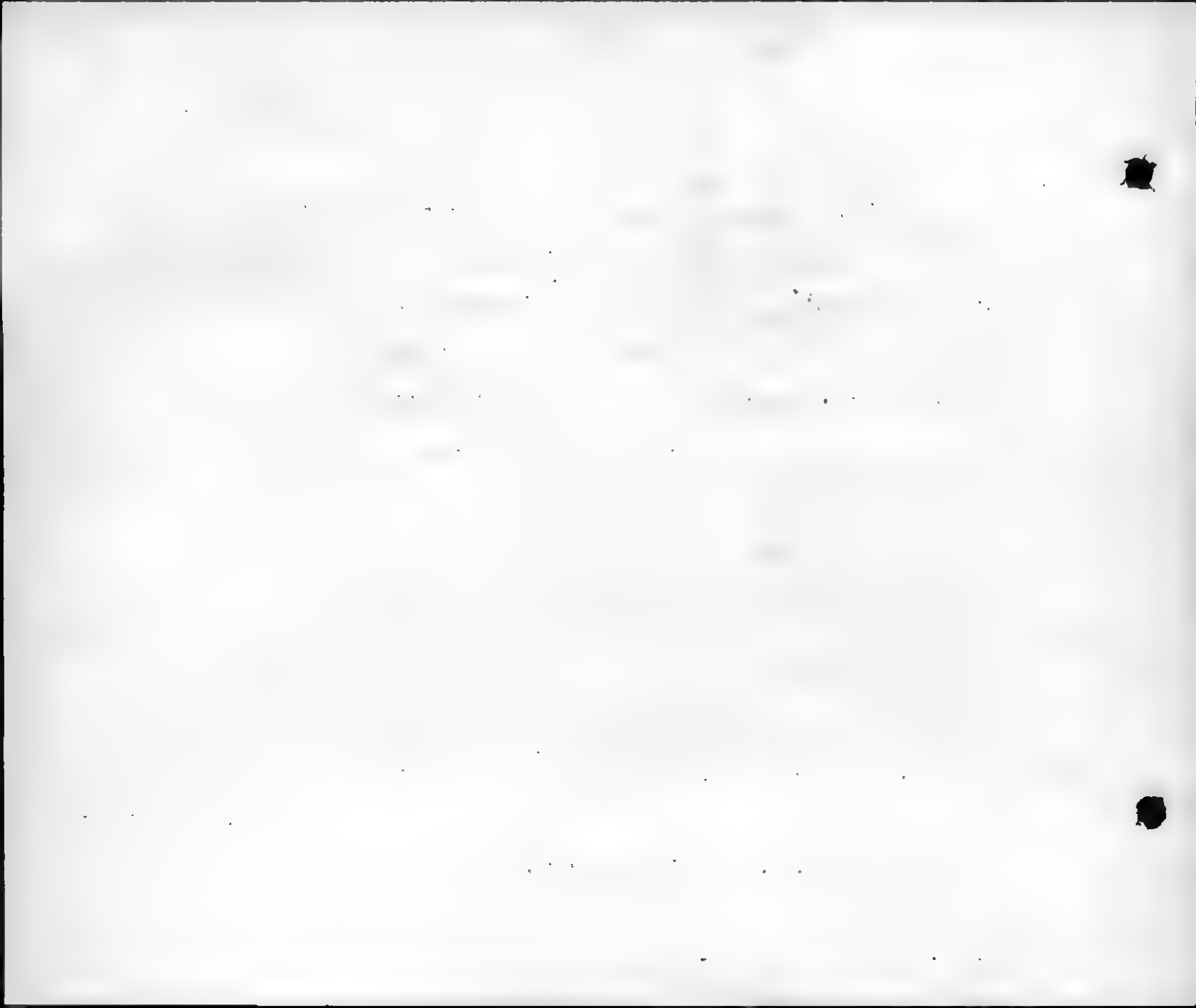
12621

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. LENGTH OF STAY IN 1b 31			
d. NAME OF HOSPITAL (If not a hospital, give street address) US ARMY HOSPITAL, ABERDEEN PROVING GROUND, MARYLAND				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Roseanne Middle Lyn Last Sandstrom				4. DATE OF DEATH Month November Day 11 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 11, 1959		9. AGE (In years last birthday) yrs. 3	10. IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert Marion Sandstrom				14. MOTHER'S MAIDEN NAME Mary Louise Northup			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N/A		16. SOCIAL SECURITY NO. N/A		17. INFORMANT Father		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hydrocephalus 752x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH 3 minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6:15 11 Nov, 1959 to 6:18 11 Nov, 1959 , that I lost sown the deceased olive on 6:17 11 Nov, 1959 , and that death occurred at 6:15A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles H. P. Westfall				DATE SIGNED US Army Hospital, Aberdeen Proving Ground, Maryland			
PHYSICIAN'S NAME (Type) CHARLES H. P. WESTFALL, Major MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11/12/59		22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery		22d. LOCATION (City, town, or county) (State) Lewistown, Taylor Co. Iowa	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Garrison				24a. REG. DAY REGISTRAR NOV 16 59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12622

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) ✓ a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY IN 1b <u>Bradshaw</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waverly</u>	
3. NAME OF DECEASED (Type or print) <u>Mary E. Scott</u>		4. DATE OF DEATH <u>November 18 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 13, 1902</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Peaker</u>		14. MOTHER'S MAIDEN NAME <u>Alice Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-22 0722</u>	
17. INFORMANT <u>Mrs., Alice Norton, Abingdon, Maryland.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture hip</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Toppa Harford MD</u>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bob Ari</u> DATE SIGNED <u>MD 11-18-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 22, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Asbury</u>	22d. LOCATION (City, town, or county) (State) <u>Lorely Balto., Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. H. Brown</u>		24a. REC'D BY REGISTRAR <u>NOV 24 '59</u>	
ADDRESS <u>Abingdon, Maryland.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Logs 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



CERTIFICATE OF DEATH

12623

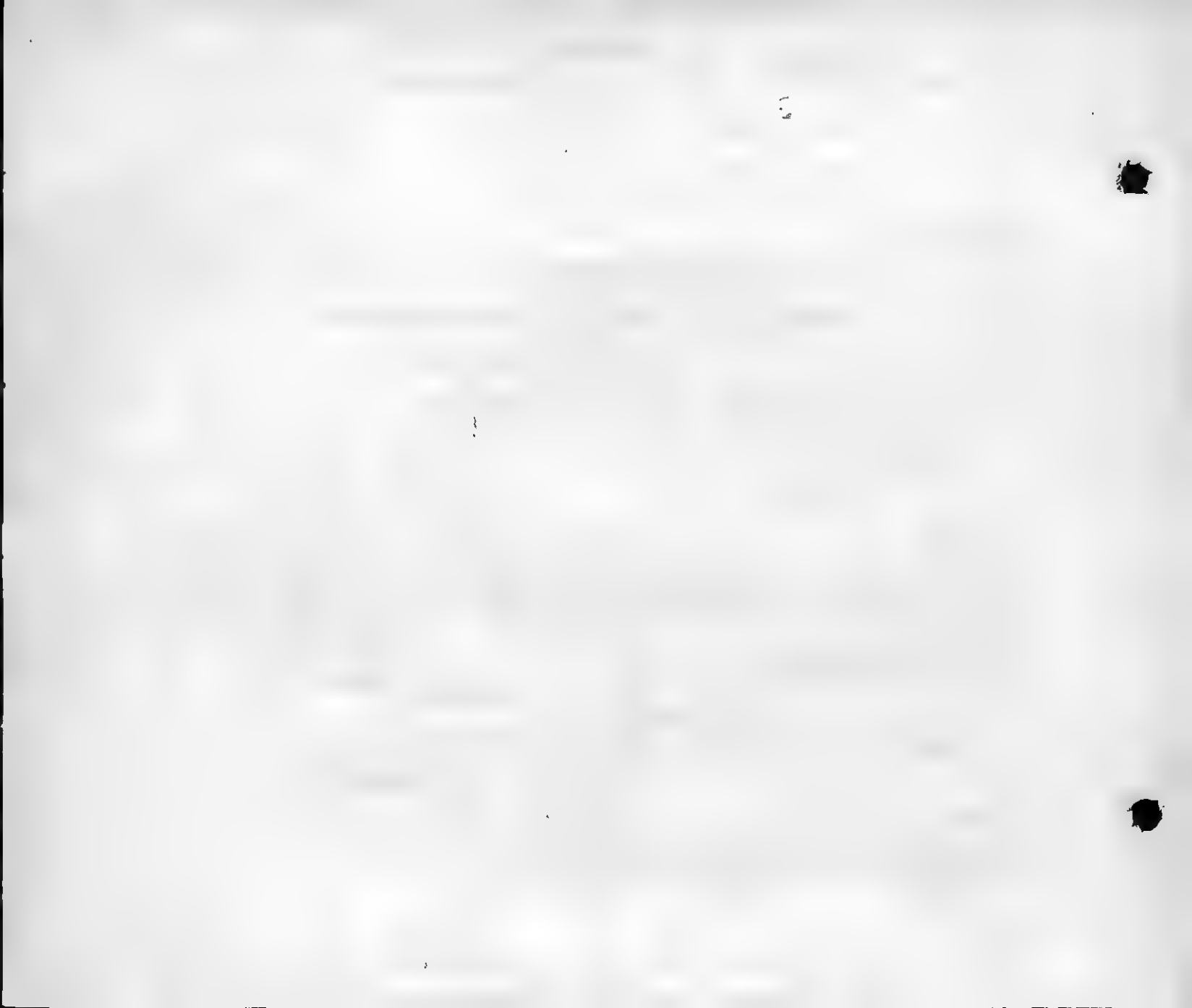
Reg. Dist. No.

12627

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. LENGTH OF STAY IN 1b 13 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.		e. STREET ADDRESS RT 2 Box 304	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle O Last SEXTON		4. DATE OF DEATH Month NOVEMBER Day 20 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 30, 1882
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALEX SEXTON		14. MOTHER'S MAIDEN NAME ELIZABETH WALLACE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-05-9110	
17. INFORMANT Mr. Russell V. Sexton Address RD #2 Box 304 Bel Air, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 194 Bilateral bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 Adenocarcinoma of thyroid (c) with metastasis to left adrenal INTERVAL BETWEEN ONSET AND DEATH 1 week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 7, 1959 to Nov. 20, 1959 , that I last saw the deceased alive on Nov. 20, 1959 , and that death occurred at 1:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Haure de Grace, Md. DATE SIGNED 11/21/59			
ACTUAL SIGNATURE Edward C. Loo, M.D.		PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov 22, 1959	22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens	22d. LOCATION (City, town, or county) (State) Bel Air, Harford Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster ADDRESS W. Broadway & W. 11th Sts. Bel Air, Maryland		24a. REC'D BY REGISTRAR NOV 24 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12624

12628

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>				STATE <u>MD</u> COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HAVRE DE GRACE</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HAVRE DE GRACE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>N. STOKES, ST.</u>				STREET ADDRESS (If rural give location) <u>N. STOKES, ST.</u>			
3. NAME OF DECEASED (Type or Print) <u>ALBERT DUGAN SKIPPER</u>				4. DATE OF DEATH <u>Nov. 9, 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>		8. DATE OF BIRTH <u>Dec. 16, 1921</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SAILOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNEMPLOYED</u>		9. AGE last birthday <u>37</u> yrs.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT W. SKIPPER</u>				14. MOTHER'S MAIDEN NAME <u>AMEY DUGAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>40324-18-7386</u>		17. INFORMANT & ADDRESS <u>JOSEPH E. WEYRAUGH ALEXANDERVA.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
4. IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						1. <u>How</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic myocarditis</u>						5. <u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1956</u> , to <u>Nov 9, 1959</u> , that I last saw the deceased alive on <u>Nov 9, 1959</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>John W. Porter M.D.</u>				ADDRESS (Street, city, town, state) <u>Havre de Grace, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11-12-1959</u>		NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>		LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>R. Madison Mitchell</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>Havre de Grace MD.</u>	
DATE <u>NOV 16 '59</u>							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12625

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belt Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belt Air</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bonnie A ne</u>		d. STREET ADDRESS <u>Bonnie A ne</u>	
3. NAME OF DECEASED (Type or print) <u>Terrance</u> First <u>Smith</u> Middle <u>S</u> Last		4. DATE OF DEATH Month <u>November</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 4, 1959</u>
9. AGE (In years last birthday) <u>2</u> Months <u>32</u> Days <u>32</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert J Smith</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Duffy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>AC 2 RT J SMITH</u>	
17. INFORMANT <u>Robert J Smith</u> Address <u>Belt Air Rd 3330000 Ave Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>✓</u> DUE TO (c) <u>✓</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Belt Air, Md</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer - MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-30-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 1/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Ignatius</u>	22d. LOCATION (City, town, or county) (State) <u>Belt Air Harford Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Lister</u> ADDRESS <u>Belt Air Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 2 '59</u>	24b. REGISTRAR'S SIGNATURE <u>C. J. L. & H. H. H.</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 14 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



CERTIFICATE OF DEATH

Reg. Dist. No.

12626

12630

1. PLACE OF DEATH a. COUNTY MARYLAND HARFORD		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harve de Grace		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harve de Grace	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital		e. STREET ADDRESS Eric Street	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle H Last Spears		4. DATE OF DEATH Month November Day 9 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/78
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR: Months 11 Days 14 Hours 15 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Harford Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Morsey Sr.		14. MOTHER'S MAIDEN NAME Ella Moore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Marjorie Boud - Harford, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis & Failure DUE TO Cerebral Arteriosclerosis Heart Disease with Cerebral Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Strangulated Ventral Hernia DUE TO (c) Strangulated Ventral Hernia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-8 , 19 58 to 11-7 , 19 59 , that I last saw the deceased alive on 11-9 , 19 59 , and that death occurred at 3:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 608 South Union Ave., Harve de Grace, Md. DATE SIGNED			
ACTUAL SIGNATURE Frank D. Hauber M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Nov. 12, 1959	Asbury Cemetery	Chesapeake, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Elmer E. Bullock		24a. REC'D BY REGISTRAR DATE NOV 16 '59	
ADDRESS Harve de Grace, Md.		24b. REGISTRAR'S SIGNATURE C. Hunt & Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form No. 3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12631 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14343

1. PLACE OF DEATH a. COUNTY Harford		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE 12 Unknown		b. COUNTY Unknown	
3. NAME OF DECEASED (Type or print) Unknown		4. DATE OF DEATH November 15, 1959		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ?	9. AGE (in years last birthday) ?	IF UNDER 1 YEAR Months ? Days ? Hours ? Min. ?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found drowned			
20c. TIME OF INJURY Month, Day, Year Hour a.m. ? 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River	
20f. (City or town) Havre de Grace, Harford, MD.		20g. (County) Harford		20h. (State) MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE Russell S. Fisher		M.D. Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/16/59	
22a. BURIAL CREMATION REMOVAL (Specify)		22b. DATE THEREOF 1.29.60		22c. NAME OF CEMETERY OR CREMATORY U.S. and Md. Naval	
23. FUNERAL DIRECTOR		22d. LOCATION (City, town, or country) Baltimore, Md.		22e. (State) MD.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Charles S. House		DATE FEB 2 '60	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12627

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) (RURAL) BEL AIR c. LENGTH OF STAY IN 1b 12 YRS		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD b. COUNTY HARFORD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (RURAL) BEL AIR d. STREET ADDRESS RD #1 Box 226	
3. NAME OF DECEASED (Type or print) VINCENT MARION WALTON		4. DATE OF DEATH Month NOVEMBER Day 30 Year 1959	
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOT KNOWN
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER'S HELPER		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-16-9876	
17. INFORMANT ROBERT T. KAHOF		Address RD #1 Box 226 BEL AIR, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA - CONGESTIVE HEART FAILURE 422.1 DUE TO FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE (c) DISEASE</p> </div> <div style="width: 45%;"> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 HRS</p> </div> </div>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Philip W. Helman		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) PHILIP W. HELMAN M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Nov 30, 1959	
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Dec 2/59	
22c. NAME OF CEMETERY OR CREMATORY St Ignatius		22d. LOCATION (City, town, or county) (State) Bel Air Rural Harford Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Foster		24a. REC'D BY REGISTRAR Bel Air Md	
24b. REGISTRAR'S SIGNATURE Bel Air Md		DATE DEC 2 '59	



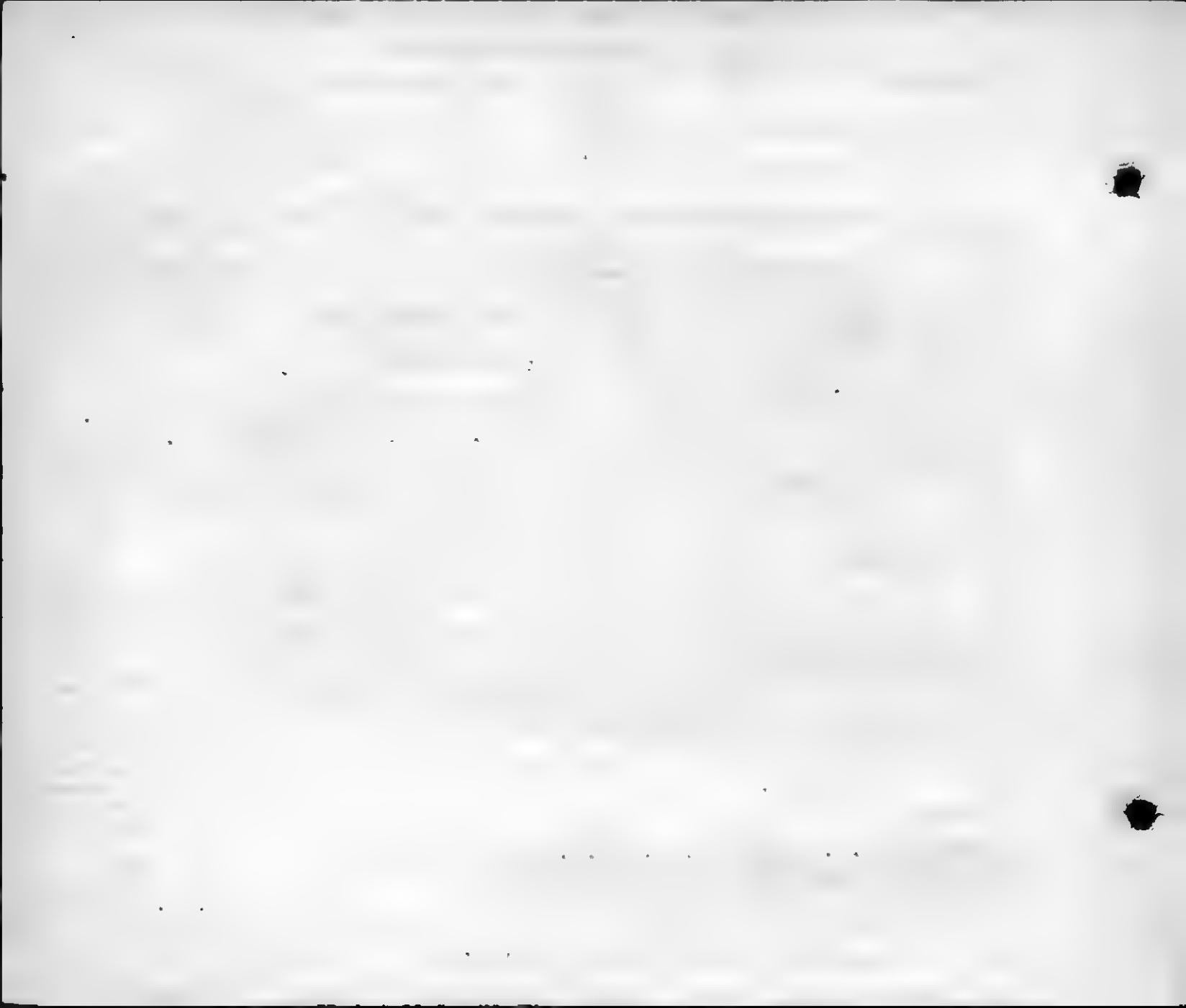
12632

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE				c. LENGTH OF STAY IN 1b 15 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 44 Havre de Grace			
f. STREET ADDRESS 555 Fountain St				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNE Middle C Last WARD				4. DATE OF DEATH Month NOVEMBER Day 12 Year 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/8/84	
9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George R. Jones				14. MOTHER'S MAIDEN NAME Martha Way			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT John R. Ward, 555 Fountain St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Bronchopneumonia 4 hours DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerosis DUE TO (c) Myocarditis						INTERVAL BETWEEN ONSET AND DEATH 5 hours 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 2, 1956 , to Nov 12, 1959 , that I last saw the deceased alive on 11-11-59 , and that death occurred at 8:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE G.H. Richards, Jr.				ADDRESS (Street, city or town, state) DATE SIGNED Port Deposit, Md. 11/12/59			
PHYSICIAN'S NAME (Type) G.H. Richards, Jr. M.D.							
22a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) Burial		22b. DATE THEREOF 11-15-1959		22c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE See a. Patterson & Son				ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE NOV 16 59	
24b. REGISTRAR'S SIGNATURE C. H. H. H.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12633

CERTIFICATE OF DEATH

Reg. Dist. No.

12629

1. PLACE OF DEATH a. COUNTY <i>Harford</i>				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>340 Wilson St</i>				d. STREET ADDRESS <i>340 Wilson Street</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Baby Boy Warfield</i>				4. DATE OF DEATH Month <i>Nov.</i> Day <i>7</i> Year <i>1959</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 6, 1959</i>	
9. AGE (In years last birthday) yrs		10. IF UNDER 1 YEAR Months <i>1</i> Days <i>1</i> Hours <i>1</i> Min		11. BIRTHPLACE (State or foreign country) <i>Harre de Grace</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>			
13. FATHER'S NAME <i>Harvey Mc Coy</i>				14. MOTHER'S MAIDEN NAME <i>Virginia E. Warfield</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>—</i>				16. SOCIAL SECURITY NO. <i>—</i>			
17. INFORMANT <i>Mrs Virginia Warfield</i>				Address <i>Harre de Grace, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congenital Alectasis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i> DUE TO (c) <i>—</i>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Prematurity</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>11/6</i> , 19 <i>59</i> , to <i>11/7</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>11/7</i> , 19 <i>59</i> , and that death occurred at <i>1:00 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>569 Revolution St. Harre de Grace, Md.</i> DATE SIGNED <i>11/7/59</i>							
ACTUAL SIGNATURE <i>George T. Stansbury</i>				PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Nov. 8, 1959</i>		<i>Union Methodist Chm.</i>		<i>Abertdeen Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Otelia J. Bullock</i>				ADDRESS <i>Harre de Grace</i>		24a. REGISTRY REGISTRAR DATE <i>NOV 12 1959</i>	
24b. REGISTRAR'S SIGNATURE <i>William E. Howard</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12646

CERTIFICATE OF DEATH

Reg. Dist. No.

12630

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>		c. LENGTH OF STAY IN 1b <u>27 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>B.</u> Last <u>Wiesser</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 8, 1889</u>
9. AGE (In years last birthday) <u>70</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Paul B. Wiesser, Joppa, Maryland.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive CVD</u> DUE TO (c) <u>10 yrs. +</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept.</u> , 19 <u>58</u> , to <u>Nov.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 11</u> , 19 <u>59</u> , and that death occurred at <u>12:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.		ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>11-11-59</u>	
PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>		<u>Kingsville, Maryland.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 13, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Air Harford Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McLean Jr</u>		ADDRESS <u>Abingdon, Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Long & Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 12631									
1. PLACE OF DEATH a. COUNTY <u>Hanford</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hanford</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanford</u>					c. LENGTH OF STAY IN 1b <u>D.O.A.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Hanford Memorial Hospital</u>					d. STREET ADDRESS <u>RD 2</u>				
3. NAME OF DECEASED (Type or print) <u>Bobby</u> First <u>O.</u> Middle <u>Walter</u> Last <u>Fong</u>					4. DATE OF DEATH <u>November 19 1959</u> Month <u>Nov</u> Day <u>19</u> Year <u>59</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/15/1936</u>		9. AGE (In years last birthday) <u>23</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Highland Co. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Chas. O. Wilfong</u>	
14. MOTHER'S MAIDEN NAME <u>Hollie Wilfong</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Address</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pending</u> <u>Asphyxia</u> <u>925.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Went down deep well & died there</u>							
20c. TIME OF INJURY Month, Day, Year Hour <u>3</u> a. m. <u>11-16</u> 19 <u>59</u> p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Road to old Farm</u>		20f. (City or town) <u>Hanford</u> (County) <u>Hanford</u> (State) <u>MD</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air Md</u> DATE SIGNED <u>11-16-59</u>				
EXAMINER'S NAME (Type) <u>Gerald E Palmer-MD</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11/21/59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Highland</u>		22d. LOCATION (City, town, or county) <u>Highland Co. Pa.</u> (State) <u>Pa.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Kenna</u> ADDRESS <u>Highland Co. Pa.</u>	
24a. REC'D BY REGISTRAR <u>NOV 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kenna</u>							

12635

CERTIFICATE OF DEATH

12632

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hanford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hanford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>	
c. LENGTH OF STAY IN 1b <u>3 hrs</u>		d. STREET ADDRESS <u>617 Juanita St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hanford Mem. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Wright</u> Last <u>Wright</u>		4. DATE OF DEATH Month <u>November</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18, 1881</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>deceased Samuel Walstrum</u>		14. MOTHER'S MAIDEN NAME <u>deceased Harriet E. Cantler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-05-2946</u>	
17. INFORMANT <u>Oscar H. Wright Sr</u>		Address <u>2614 Aisquith Baltimore 18, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> (c) <u>Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>3 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 25, 1959</u> to <u>Nov 25, 1959</u> that I last saw the deceased alive on <u>Nov 25, 1959</u> , and that death occurred at <u>3:20 PM</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irvin Wachsman M.D.</u>		ADDRESS (Street, city or town, state) <u>407 S. Union Ave; Hanover, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Irvin Wachsman, M.D.</u>		DATE SIGNED <u>11/26/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Run Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>R.D. Havre de Grace, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Tarring</u>		24. REC'D BY REGISTRAR <u>DEC 1 1959</u>	
ADDRESS <u>Aberdeen, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

